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FORM APPROVED

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL056005	A. BUILDING _____ B. WING _____	R 06/18/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CHESTNUT HILL OF HIGHLAND	64 CLUBHOUSE TRAIL HIGHLANDS, NC 28741

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
D 000	Initial Comments The Adult Care Licensure Section conducted an annual survey and follow up from 06/17/25 through 06/18/25.	D 000	**D234** **To ensure a smooth transition for new residents, a four-step process has been implemented:** **Nurse Responsibilities: The assigned nurse is responsible for completing Step 1 prior to the resident's move-in date. Step 2 must be completed within the first 30 days of the resident's stay.** **Medication Staff Responsibilities: Before a resident moves in, the medication staff will verify that Step 1 has been completed by checking the resident's chart. Within the first 30 days of the resident's stay, the medication staff will re-check the chart to confirm the completion of Step 2.** **Assistant Administrator Responsibilities:Complete a chart audit prior to the move-in date to ensure Step 1 is finalized. Follow up in 30 days for Step 2.** **Administrator Responsibilities: The administrator will conduct a chart audit to ensure that both Step 1 and Step 2 have been successfully completed for all residents.**	**07/10/25**
D 234	10A NCAC 13F .0703(a) Tuberculosis Test, Medical Exam & Immunizatio 10A NCAC 13F .0703 Tuberculosis Test, Medical Examination & Immunizations (a) Upon admission to an adult care home each resident shall be tested for tuberculosis disease in compliance with the control measures adopted by the Commission for Public Health as specified in 10A NCAC 41A .0205 including subsequent amendments and editions. This Rule is not met as evidenced by: Based on record reviews and interviews, the facility failed to ensure 2 of 3 sampled residents (Residents #2 and #1) were tested upon admission for tuberculosis (TB) disease in compliance with the control measures for the Commission for Health Services. The findings are: 1. Review of Resident #2's current FL2 dated 02/26/25 revealed diagnoses included type 2 diabetes, sleep apnea, chronic diastolic congestive heart failure, and essential hypertension. Review of Resident #2's record revealed no	D 234		

Division of Health Service Regulation
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE — TITLE — (X6) DATE

Linda Tiffany — Administrator — 7-24-25

STATE FORM 6899 — IYUX11 — If continuation sheet 1 of 19

Reviewed & Acknowledged JMD 7-24-25

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D 234	Continued From page 1 Resident Register. Interview with the Business Office Manager (BOM) on 06/18/25 at 10:53am revealed Resident #2's admission date was 03/22/25. Review of Resident #2's record revealed there was no documentation a 2-step TB test or a chest x-ray was completed. Refer to the interview with the BOM on 06/18/25 at 1:55pm. Refer to the interview with the Administrator on 06/18/25 at 2:07pm. 2. Review of Resident #1's current FL2 dated 08/30/24 revealed diagnoses included heart failure, high blood pressure, and gastric reflux. Review of Resident #1's Resident Register revealed an admission date of 09/14/23. Review of Resident #1's record revealed there was no documentation a 2-step TB test or a chest x-ray was completed. Refer to the interview with the BOM on 06/18/25 at 1:55pm. Refer to the interview with the Administrator on 06/18/25 at 2:07pm. Interview with the Business Office Manager (BOM) on 06/18/25 at 1:55pm revealed: -TB tests were completed by the Registered Nurse (RN). -The facility had been without an RN for a couple weeks. -In the absence of an RN, she or the Activity	D 234	**D234** **To ensure the resident register is always completed, we have implemented a three-step process:** **Med Staff Responsibility: Medical staff will ensure the register is submitted with all accompanying paperwork.** **Assistant Administrator Pre-Move-in Audit: The assistant administrator will conduct a chart audit before move-in to confirm the register is completed and signed.** **Administrator Post-Move-in Audit: The administrator will perform a chart audit within the first week of move-in to verify the register is completed and signed.**	07/12/25

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D 234	Continued From page 2 Director (AD), would take residents to a physician's office for the TB tests to be performed. -She thought all the TB tests were up to date. -It was her responsibility to check to make sure paperwork was completed when the RN was not available. Interview with the Administrator on 06/18/25 at 2:07pm revealed: -TB tests were to be completed upon admission. -She did not know some residents did not have documentation TB tests were completed in the records. -The RN was responsible to make sure TB tests were completed and paperwork was up to date. -The BOM was responsible for making sure TB tests were completed and paperwork was up to date in the absence of the RN. -They had been without an RN for a couple weeks. -It was her expectation that TB tests were to be completed upon admission and a second step given after. -She had not been doing chart audits.	D 234	**D253** **To ensure all assessments are completed within the initial 72 hours, the nurse will train the Residential Care Coordinator (RCC), two members of the medical staff, the Assistant Administrator, and the Administrator on proper assessment procedures, utilizing the NC DHSR ACLS RESIDENT ASSESSMENT SELF-INSTRUCTIONAL MANUAL FOR ADULT CARE HOMES.** **The assessment process will adhere to the following timeline:** **Within the first 24 hours: The nurse is responsible for completing the assessment.** **After 24 hours: If the nurse has not completed the assessment, the medical staff will check and perform it.** **Within the first 48 hours: The Assistant Administrator will verify if the assessment has been completed. If not, they will complete it.** **Within the first 72 hours: The Administrator will ensure the assessment has been finalized. If not, they will complete it at that time.**	07/21/25
D 253	10A NCAC 13F .0801(a) Resident Assessment 10A NCAC 13F .0801 Resident Assessment (a) An adult care home shall assure that an initial assessment of each resident is completed within 72 hours of admission using the Resident Register.	D 253		

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D 253	Continued From page 3	D 253		

This Rule is not met as evidenced by:
Based on interviews and record reviews, the facility failed to ensure an initial assessment was completed within 72 hours of admission using the Resident Register for 1 of 3 sampled residents (#2).

The findings are:

Review of Resident #2's current FL2 dated 02/26/25 revealed diagnoses included diabetes, sleep apnea, chronic diastolic congestive heart failure, and hypertension.

Review of Resident #2's record revealed no documentation of a Resident Register.

Interview with the Business Office Manager (BOM) on 06/18/25 at 10.53am revealed Resident #2's admission date was 03/22/25.

Interview with the Resident Care Coordinator (RCC) on 06/18/25 at 1.49pm revealed:
-The Activity Director (AD) or the Business Office Manager (BOM) completed Resident Registers.
-After the Resident Registers were completed, she was responsible for placing them into the records.
-She thought a Resident Register was completed for Resident #2, but she could not locate it.
-She did not know what happened to Resident #2's Resident Register.

Interview with the BOM on 06/18/25 at 1:55pm revealed:
-She was responsible for completing Resident Registers.

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D 253	Continued From page 4 -She would give families packets to fill out containing the Resident Registers, then once they completed them, she would sign them. -She thought Resident #2 had a Resident Register, but she was not sure why it could not be located. -She and the Administrator were responsible for making sure the Resident Registers were completed and placed in the resident's record. Interview with the Administrator on 06/18/25 at 2:07pm revealed: -The BOM had been completing Resident Registers. -She expected Resident Registers would be completed prior to admission or within 72 hours of admission. -She did not realize Resident #2 did not have a Resident Register in her record. -She had not been doing chart audits.	D 253	**D263** **To ensure all resident care plans are current and signed by their physician, we will implement a four-step process:** **Nurse Responsibility: The nurse will complete all care plans annually or when a significant change in care occurs. Completed care plans will be immediately sent to the physician's office for review and signature.** **RCC Follow-up (Day 5): The Resident Care Coordinator (RCC) will conduct chart audits. If a care plan has not been signed and returned by the fifth day, the RCC will contact the physician's office for follow-up.** **Assistant Administrator Follow-up (Day 10): The assistant administrator will conduct a chart audit by the tenth day. If the care plan remains unsigned and unreturned, she will personally go to the physician's office for follow-up.** **Administrator Escalation (Day 14): The administrator will conduct a final chart audit by the fourteenth day. If the care plan is still unsigned and unreturned, she will directly contact the physician to ensure its completion within 24 hours.**	07/24/25
D 263	10A NCAC 13F .0802 (e) Resident Care Plan 10A NCAC 13F .0802 Resident Care Plan (e) The facility shall assure that the resident's physician authorizes personal care services and certifies the following by signing and dating the care plan within 15 calendar days of completion of the assessment: (1) the resident is under the physician's care; and (2) the resident has a medical diagnosis with associated physical or mental limitations that justify the personal care services specified in the care plan. This Rule is not met as evidenced by: Based on record reviews and interviews the	D 263		

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O 263	Continued From page 5	O 263		

facility failed to ensure the physician signed and dated the care plan for 3 of 3 sampled residents (Resident #1, #2, and #3).

The findings are:

1. Review of Resident #1's current FL2 dated 08/30/24 revealed diagnoses included heart failure, high blood pressure, blindness, history of recent falls and gastric reflux.

Review of Resident #1's Resident Register revealed an admission date of 09/14/23.

Review of Resident #1's care plan dated 05/06/25 revealed:
-Resident #1 required limited assistance with ambulation, toileting, and dressing.
-Resident #1 required supervision with bathing, grooming, and transfers.
-Resident #1's care plan was not signed by the primary care provider (PCP).

Refer to the interview with a personal care aide (PCA) on 06/18/25 at 1:48pm.

Refer to the interview with the Resident Care Coordinator (RCC) on 06/17/25 at 12:45pm.

Refer to the interview with the Administrator on 06/18/25 at 2:07pm.

2. Review of Resident #2's current FL2 dated 02/26/25 revealed diagnoses included type 2 diabetes, sleep apnea, chronic diastolic congestive heart failure, and essential hypertension.

Review of Resident #2's Record revealed no Resident Register.

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D 263	Continued From page 6	D 263		

Interview with the Business Office Manager (BOM) on 06/18/25 at 10:53am revealed Resident #2's admission date was 03/22/25.

Review of Resident #2's care plan dated 03/18/25 revealed:
-Resident #2 did not have a history of wandering behaviors.
-Resident #2 was independent with activities of daily living (ADL's).
-Resident #2 required staff to check on her every 2 hours at night.
-Resident #2 required assistance with medication management.
-The care plan was not signed by Resident #2's PCP.

Refer to the interview with a personal care aide (PCA) on 06/18/25 at 1:48pm.

Refer to the interview with the Resident Care Coordinator (RCC) on 06/17/25 at 12:45pm.

Refer to the interview with the Administrator on 06/18/25 at 2:07pm.

3. Review of Resident #3's current FL2 dated 08/28/24 revealed there were no diagnoses listed on the FL2 or on the physician's orders.

Review of the hospice progress notes by the primary care provider (PCP) dated 06/02/25 revealed diagnoses include Alzheimer's disease, diabetes, high blood pressure, and abnormal weight loss.

Review of Resident #3's Resident Register revealed an admission date of 09/02/16.

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D 263	Continued From page 7	D 263		

Review of Resident #3's care plan dated 03/16/25 revealed:
-Resident #3 required total assistance with bathing, dressing, toileting, transfers and ambulation.
-Resident #3 required extensive assistance with eating and grooming.
-Resident #3's care plan was not signed by the PCP.

Refer to the interview with a personal care aide (PCA) on 06/18/25 at 1:48pm.

Refer to the interview with the Resident Care Coordinator (RCC) on 06/17/25 at 12:45pm.

Refer to the interview with the Administrator on 06/18/25 at 2:07pm.

Interview with the PCA on 06/18/25 at 1:48pm revealed:
-Care plans should be completed yearly and any time a significant change occurred.
-She entered information from care plans and FL2s in a book in the medication room that she referred to for each resident to provide appropriate care.

Interview with the RCC on 06/17/25 at 12:45pm revealed:
-She was unable to find current care plans for the residents that were signed by the PCP.
-All the care plans were supposed to be signed by the PCP for each resident.
-The Registered Nurse (RN) was responsible for getting the PCP signatures on the care plans for each resident.

Interview with the Administrator on 06/18/25 at 2:07pm revealed:

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D 263	Continued From page 8 -The RN and RCC were responsible for completing care plans and making sure the physician's signed each care plan. -She had been without an RN for about 2 weeks. -She did not realize care plans were not signed by a physician. -Sometimes they could not get the physician to sign the care plans right away. -She was responsible for checking records and making sure care plans were signed by the physician. -She had not been doing chart audits.	D 263	**D280** **To ensure timely completion of the Licensed Health Professional Support (LHPS) form, the following process has been implemented:** **Nurse Responsibilities:** **Complete the initial evaluation within 30 days of a resident's move-in.** **Complete the form whenever a new resident need arises.** **Complete the form quarterly thereafter.** **RCC (Resident Care Coordinator) Audit:** **Conduct a chart audit 15 days after move-in to confirm LHPS completion.** **If incomplete, notify the nurse and assistant administrator.** **Assistant Administrator Audit:** **Conduct a chart audit 20 days after move-in to confirm LHPS completion.** **If incomplete, notify the nurse and administrator.** **Administrator Audit:** **Conduct a chart audit 25 days after move-in if the LHPS is not completed.** **If incomplete, schedule the nurse to come in and complete the form.**	08/30/25
D 280	10A NCAC 13F .0903(c) Licensed Health Professional Support 10A NCAC 13F .0903 Licensed Health Professional Support (c) The facility shall assure that participation by a registered nurse, occupational therapist or physical therapist in the on-site review and evaluation of the residents' health status, care plan and care provided, as required in Paragraph (a) of this Rule, is completed within the first 30 days of admission or within 30 days from the date a resident develops the need for the task and at least quarterly thereafter, and includes the following: (1) performing a physical assessment of the resident as related to the resident's diagnosis or current condition requiring one or more of the tasks specified in Paragraph (a) of this Rule; (2) evaluating the resident's progress to care being provided; (3) recommending changes in the care of the resident as needed based on the physical assessment and evaluation of the progress of the resident; and (4) documenting the activities in Subparagraphs	D 280		

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D 280	Continued From page 9	D 280		

(1) through (3) of this Paragraph.

This Rule is not met as evidenced by:
Based on record reviews and interviews the facility failed to ensure 2 of 3 sampled residents (Resident #1 and #3) had a Licensed Health Professional Support (LHPS) review completed quarterly by an appropriate licensed health professional.

The findings are:

1. Review of Resident #1's current FL2 dated 08/30/24 revealed diagnoses included heart failure, high blood pressure, frequent falls, and blindness.

Review of Resident #1's record revealed:
-The most current LHPS review was dated 05/08/25 and included personal care tasks documented as medication administration, range of motion exercises for edema, monitor for falls, and encourage to join activities.
-The previous LHPS review was dated 11/16/24.

Refer to interview with the Resident Care Coordinator on 06/17/25 at 12:45pm.

Refer to interview with the Administrator on 06/18/25 at 2:08pm.

2. Review of Resident #3's current FL2 dated 08/28/24 revealed there were no diagnoses listed on the FL2 or on the physician's orders.

Review of the hospice progress notes by the primary care provider (PCP) dated 06/02/25 revealed diagnoses include Alzheimer's disease, diabetes, high blood pressure, and abnormal weight loss.

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D 280	Continued From page 10 Review of Resident #3's record revealed: -The most current LHPS review was dated 05/08/25 and included personal care tasks documented as administer pain and comfort medications, assist with activities of daily living, encourage activities as she tolerates, and hospice care coordination. -The previous LHPS review was dated 11/16/24. Refer to interview with the Resident Care Coordinator on 06/17/25 at 12:45pm. Refer to interview with the Administrator on 06/18/25 at 2:08pm. Interview with the Resident Care Coordinator on 06/17/25 at 12:45pm revealed: -The Registered Nurse (RN) was responsible to ensure the LHPS was completed quarterly. -The facility did not currently have an RN on staff. -She did not know who was resonsible for the LHPS to be completed quarterly in the absence of the RN. Interview with the Administrator on 06/18/25 at 2:08pm revealed: -She was not sure how often the LHPS review was supposed to be done. -The RN was responsible to complete the LHPS review. -She was not aware the LHPS review was not being completed timely.	D 280		
D 309	10A NCAC 13F .0904(e)(3) Nutrition and Food Service 10A NCAC 13F .0904 Nutrition and Food Service (e) Therapeutic Diets in Adult Care Homes:	D 309		

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D 309	Continued From page 11 (3) The facility shall maintain a current listing of residents with physician-ordered therapeutic diets for guidance of food service staff. This Rule is not met as evidenced by: Based on observations, record reviews, and interviews, the facility failed to maintain an accurate listing of residents with physician ordered therapeutic diets for guidance of food service staff for 3 of 5 residents sampled (Residents #2, #3, and #4). The findings are: Observation of the kitchen on 06/17/25 at 9:50am revealed there was a list of physician-ordered therapeutic diets posted for staff to reference. 1. Review of Resident #2's current FL2 dated 02/26/25 revealed diagnoses included type 2 diabetes, sleep apnea, chronic diastolic congestive heart failure, and essential hypertension. Review of Resident #2's Record revealed no Resident Register. Interview with the Business Office Manager (BOM) on 06/18/25 at 10:53am revealed Resident #2's admission date was 03/22/25. Observation of the diet list on 06/17/25 at 9:49am revealed Resident #2 was on a regular diet.	D 309	**D309** **To ensure all dietary and therapeutic needs are met, the following process has been implemented:** **Nurse Responsibility: The nurse will verify that all diet orders are documented in the resident's chart and signed by the resident physicians.** **RCC Responsibility: The Resident Care Coordinator (RCC) will create a copy of the diet order for the dietary staff. If a new order is received, the RCC will replace the outdated order.** **Assistant Administrator Responsibility: The assistant administrator will conduct monthly audits to confirm that resident charts align with the diet orders posted in the kitchen.** **Administrator Responsibility: The administrator will perform quarterly audits to ensure all diet orders in resident charts match those posted in the kitchen.**	08/01/25

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D 309	Continued From page 12	D 309		

Review of Resident #2's physician's order dated 05/12/25 revealed Resident #2 was ordered a low sodium diet and no added table salt.

Interview with the Resident Care Coordinator (RCC) on 06/17/25 at 12:39pm revealed:
-She thought Resident #2 was on a regular diet.
-She must have missed the diet order on 05/12/25 where her diet changed to low sodium diet with no added table salt.

Interview with the Dietary Manager (DM) on 06/17/25 at 9:50am revealed:
-She was not aware Resident #2 was on a low sodium diet and no added table salt.
-She never added salt when she prepared the food.

Refer to interview with the Dietary Manager (DM) on 06/18/25 at 11:31am.

Refer to interview with the Business Office Manager (BOM) on 06/17/25 at 12:20pm.

Refer to interview with the Resident Care Coordinator (RCC) on 06/17/25 at 12:39pm.

Refer to interview with the cook on 06/18/25 at 9:14am.

Refer to interview with the Administrator on 06/18/25 at 10:54am.

2. Review of Resident #3's current FL2 dated 08/28/24 revealed there were no diagnoses listed on the FL2 or on the physician's orders.

Review of the hospice progress notes by the primary care provider (PCP) dated 06/02/25

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL056005	A. BUILDING: _____ B. WING _____	R 06/18/2025

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D 309	Continued From page 13 revealed diagnoses include Alzheimer's disease, diabetes, high blood pressure, and abnormal weight loss. Observation of the diet list on 06/17/25 at 9:49am revealed Resident #3 was on a low concentrated, carb-controlled diet, dated 05/21/24. Review of Resident #3's physician's order dated 03/12/25 revealed Resident #3 was ordered a mechanical soft diet. Review of Resident #3's physician's order dated 06/05/25 revealed Resident #3 was on a regular diet. Interview with Resident #3's hospice Registered Nurse (RN) on 06/18/25 at 11:20am revealed: -Resident #3 was having trouble chewing food back in March 2025 and she was placed on a mechanical soft diet. -Resident #3 was no longer having any issues with chewing and the family and the care team decided it was best to put her on a regular diet. -She was not sure of the exact date the mechanical soft diet was discontinued. -She no longer had blood sugar tested or required blood sugar medications and no longer needed the low concentrated sweets or carb controlled diet. -They were more concerned with Resident #3's comfort and providing her with a regular diet so she could eat the food she chose to eat. Refer to interview with the DM on 06/18/25 at 11:31am. Refer to interview with the BOM on 06/17/25 at 12:20pm.	D 309		

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D 309	Continued From page 14 Refer to interview with the RCC on 06/17/25 at 12:39pm. Refer to interview with the cook on 06/18/25 at 9:14am. Refer to interview with the Administrator on 06/18/25 at 10:54am. 3. Review of Resident #4's current FL2 dated 11/18/24 revealed: -Diagnoses included type 2 diabetes, hypertension and history of stroke. -There was an order for a regular diet. Observation of the diet list on 06/17/25 at 9:49am revealed: -Resident #4 was on a low concentrated sweets and no added salt diet. -There was an order on the clipboard dated 11/18/24 for low concentrated sweets and no added salt diet with no physician signature. Refer to interview with the DM on 06/18/25 at 11:31am. Refer to interview with the BOM on 06/17/25 at 12:20pm. Refer to interview with the RCC on 06/17/25 at 12:39pm. Refer to interview with the cook on 06/18/25 at 9:14am. Refer to interview with the Administrator on 06/18/25 at 10:54am. Interview with the Dietary Manager (DM) on 06/18/25 at 11:31am revealed:	D 309		

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D 309	Continued From page 15	D 309		

-The Business Office Manager (BOM) kept her informed of new diet orders.
-She and the cooks would place a copy on the clipboard and update the resident list with any diet changes.

Interview with the BOM on 06/17/25 at 12:20pm revealed the Resident Care Coordinator (RCC) was responsible for processing all of the diet orders and ensuring the kitchen staff received the diet orders.

Interview with the RCC on 06/17/25 at 12:39pm revealed:
-When Residents were admitted to the facility or when a new diet was ordered, the physician would either call or fax the order.
-She was responsible for making copies of the orders and immediately sending orders to the kitchen.
-She was not aware of any diet order changes.
-She was not sure why they did not have the most recent diet order listed for the kitchen.

Interview with the cook on 06/18/25 at 9:14am revealed:
-The BOM verbally informed him of new diet orders.
-The BOM also gave him hardcopies of the diet orders.
-He thought the current list of resident diets were accurate.

Interview with the Administrator on 06/18/25 at 10:54am revealed:
-The RCC was responsible for ensuring new diet orders communicated to the kitchen staff.
-Physician orders were faxed or hand delivered to the RCC, and the RCC would make a copy and take to the kitchen.

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D 309	Continued From page 16 -She expected the kitchen to find out immediately of any diet orders or changes. -She did not know orders were incorrect on the diet list the kitchen was using.	D 309		
D 349	10A NCAC 13F .1002 (f) Medication Orders 10A NCAC 13F .1002 Medication Orders (f) The facility shall assure that all current orders for medications or treatments, including standing orders and orders for self-administration are reviewed and signed by the resident's physician or prescribing practitioner at least every six months. This Rule is not met as evidenced by: Based on interviews and record reviews, the facility failed to ensure all current orders for medications and treatments were reviewed and signed by the resident's primary care provider (PCP) at least every 6 months for 2 of 3 sampled residents (Resident #1 and #3). The findings are: 1. Review of Resident#1's current FL2 dated 08/30/24 revealed: -Diagnoses included chronic pain of the knee, back, and shoulder, heart disease, heart failure, high blood pressure, cardiomyopathy (disease of the heart muscle), blindness, seasonal allergies, frequent falls, gastric reflux, and history of myocardial infarction (heart attack). -There was no recommended level of care. -See attached medication list was documented in the medication orders section.	D 349	**D349** **To ensure all medication orders are current and signed by resident physicians, the following process has been implemented:** **Every five months, the RCC (Resident Care Coordinator) will print and send all medication orders to physicians for updates and signatures.** **At the 5.5-month mark, the RCC will contact physicians regarding any outstanding needs and inform the assistant administrator.** **Assistant Administrator Audit and Follow-up:** **Every six months, the assistant administrator will audit each resident's chart to verify that medication orders have been updated and signed by their physicians.** **If any outstanding orders are identified, the assistant administrator will visit the doctor's office to obtain the necessary signatures and then update the administrator.** **Administrator Audit:** **The administrator will audit charts to ensure that medication orders have been updated and signed.**	**08/15/25**

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D 349	Continued From page 17	D 349		

-There were no physician's orders attached to Resident #1's FL2 or in the record dated 08/30/24.

Review of Resident #1's physician's orders revealed there was no six-month medical provider renewal of all medications and treatments for Resident #1.

Refer to interview with the Resident Care Coordinator (RCC) on 06/17/25 at 12:45pm.

Refer to interview with the Administrator on 06/18/25 at 2:08pm.

2. Review of Resident #3's current FL2 dated 08/28/24 revealed:
-There were no diagnosis listed.
-The recommended level of care was ALF (assisted living facility).
-There was an order for B complex (used to treat vitamin B deficiency) 0.4mg three times daily, Biofreeze gel (used topically to relieve pain) 4%/ml apply to elbow, knees, shoulder, and back daily, celecoxib (used to treat pain) 100mg twice daily, furosemide (used to treat fluid retention) 40mg daily, ipratropium-albuterol (used to treat breathing disorders) inhale one 3ml vial by nebulizer twice daily, levothyroxine (used to treat hypothyroidism) 75mcg daily, omeprazole (used to treat gastric reflux) 20mg daily, potassium (used to treat low potassium) 10meq twice daily, Perservision AREDS (used for eye health) 1 tablet daily, vitamin D3 (used to maintain bone health) 2000iu daily, and Voltaren (used topically to treat pain) 1% gram gel, apply 2gm to affected area every night.

Review of Resident #3's physician's orders revealed there was no six-month medical provider

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D 349	Continued From page 18 renewal of all medications and treatments for Resident #3. Refer to interview with the RCC on 06/17/25 at 12:45pm. Refer to interview with the Administrator on 06/18/25 at 2:08pm. Interview with the RCC on 06/17/25 at 12:45pm revealed: -The Registered Nurse (RN) was responsible to ensure the physician's orders were completed every 6 months and placed in the resident's medical record. -The facility was currently without an RN. -She was not sure who was responsible for the physician's orders in the absence of the RN. Interview with the Administrator on 06/18/25 at 2:08pm revealed: -In the last year, she had 3 different RN's who were each responsible for auditing records and ensuring the physician's orders were completed every 6 months for all the residents. -She was unaware some of the residents did not have 6-month physician's orders in their medical records.	D 349		